



Special points of interest:

- This communication is not intended to provide specific medical recommendations and interested parties should seek further clarification from trained medical professionals.
- The following issues were identified during mortality reviews completed during the first and second quarter of fiscal year 2012 (July through December 2011).
- While the data presented may pertain to comorbid conditions that are not attributable to the cause of death, the risk involved with these conditions warrant further examination.
- It is hoped that this communication will lead to an increased awareness of the issues discussed and that this knowledge will translate to individual and systemic actions intended to reduce recurrence.

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Bureau of Quality Improvement Services

Mortality Communication

December 20, 2011

Diabetes

November was National Diabetes Awareness Month. Nearly 26 million Americans have diabetes, according to estimates from the Centers for Disease Control and Prevention (CDC) released in January 2011. In addition, an estimated 79 million U.S. adults have prediabetes, a condition in which blood sugar levels are higher than normal, but not high enough to be diagnosed as diabetes. Prediabetes raises a person's risk of type 2 diabetes, heart disease and stroke.

Diabetes affects 8.3 percent of Americans of all ages, and 11.3 percent of adults aged 20 and older, according to the National Diabetes Fact Sheet for 2011. About 27 percent of those with diabetes (i.e., 7 million Americans) do not know they have the disease. Prediabetes affects 35 percent of adults aged 20 and older.

Diabetes is the seventh leading cause of death in the United States. People with diabetes are more likely to suffer from complications such as heart attacks, strokes, high blood pressure, kidney failure, blindness and amputations of feet and legs. Diabetes costs \$174 billion annually, including \$116 billion in direct medical expenses.

<http://apps.nccd.cdc.gov/DDTSTRS/FactSheet.aspx>
http://www.cdc.gov/media/releases/2011/p0126_diabetes.html

Indiana Data. For those deaths reviewed by MRC from 02/01/2009 through 10/01/2011, eight people had a diagnosis of diabetes insipidus and 258 people had a diagnosis of diabetes mellitus.

Diabetes Mellitus vs. Diabetes Insipidus

Provider agencies should ensure that risk plans/health care plans are created to match the diagnoses of the individual. When in doubt, ask a nurse or other health care professional for assistance in determining the correct risk plan/health care plan that is applicable to the individual. Of special importance, diabetes mellitus and diabetes insipidus are two different entities with distinct treatment. The word 'diabetes' refers to the Greek word for excessive urine output. However, similarity of these two illnesses ends at that point.

Diabetes mellitus requires the need to monitor and treat abnormal blood sugar levels, which often causes

frequent urination of large volumes.

Diabetes insipidus involves loss of ability to concentrate urine with excessive volume of urine and potential serious derangement in sodium levels in the blood.

One requires attention to sugar levels (diabetes mellitus), and one requires attention to sodium levels (diabetes insipidus). The medications, treatments, and monitoring of the two are different. Both can be life threatening without appropriate risk plans/health care plans. If only the term 'diabetes' is written on an office or hospital communication as a new diagnosis, this may require clarification and assistance from health care professionals in order to provide appropriate treatment. It is important to note that a risk plan/health care plan for diabetes mellitus will not treat diabetes insipidus and vice versa.

http://www.medicinenet.com/diabetes_mellitus/article.htm
<http://diabetes.webmd.com/what-is-diabetes-insipidus>
http://www.medicinenet.com/diabetes_insipidus/article.htm

Psychogenic Polydipsia

Psychogenic Polydipsia is a condition in which there is excessive drinking of water. While medical causes such as diabetes can lead to an increase in fluid consumption, there may be underlying behavioral or psychiatric contributors to this condition.

What do staff need to watch for? Behavioral examples to record include frequent ingestion/guzzling of glasses of water, drinking out of a

sink faucet, shower head when showering, faucet or tub water when bathing, and vocalizations indicating obsession with thirst.

Prevalence

While the prevalence of this condition in outpatient settings is unknown, incidents reported to DDRS have been associated with display of behavioral incidents (e.g., self-injury, physical aggression) in re-

sponse to fluid restrictions, risk plan development, and specialist involvement (i.e., endocrinology).

Indiana Data: During Mortality Review Committee (MRC) reviews, a case of Polydipsia was noted to have led to seizures. From the period 01/01/2011 through 11/30/2011, 12 incident reports submitted to Indiana's DDRS included reference to Polydipsia (or water intoxication).

Psychogenic Polydipsia (cont.)



Complications

Complications from this condition can range from increased urination (i.e., polyuria) to more serious conditions such as disturbances in electrolyte balance, which can result in a rapid decrease in serum sodium concentration (i.e., hyponatremia), and even death. Increased risk of fatigue, irritability, poor seizure control, heart attack, and stroke have also been attributed to Psychogenic Polydipsia.

Treatment

Once medical causes are ruled out

(or addressed), additional interventions may be necessary to assure the health and welfare of the affected person. This may include any number of interventions such as fluid restriction, increased supervision, behavioral strategies, and psychiatric intervention.

When considering fluid restrictions, a number of factors must be taken into account. What fluid restriction is indicated? Should this be a number of CCs or MLs of fluid, such as a 2000cc per day fluid restriction? How is fluid intake measured? This will require nursing or medical support to develop a system in which this is measured and logged

each 24 hours. When completing an appointment with the person's primary care physician, this information should be brought along for review.

With the risk of hyponatremia, serum sodium should be measured (seek guidance from a physician/medical professional). The medical team may wish to push fluids that can improve the sodium level such as Gatorade and tomato juice due to their high salt content.

More intensive behavioral or psychiatric intervention may be necessary if excessive fluid intake continues.

For Pica ...

“Research has noted prevalence rates above 20% for those diagnosed with an intellectual or developmental disability.”

Ashworth, M., Martin, L., & Hirdes, J. (2008). *Journal of Mental Health Research in Intellectual Disabilities*, 1.3, 176—190.

Pica

Pica involves the ingestion of non-edible substances/items. Research has noted prevalence rates above 20% for those diagnosed with an intellectual or developmental disability (Ashworth, Martin, & Hirdes, 2008) with an elevated risk associated with the following characteristics: Male, diagnosis of autism, and use of non-verbal communication.

Indiana Data: From 03/01/2011 through 09/30/2011, there were 38 reported incidents of pica that required this level of intervention.

A case was reviewed through MRC which included ingestion of liquid products (e.g., hand sanitizer, liquid soap, mouth wash). It is important to note that ingestion of non-consumable liquid is also considered pica.

As noted in the [DDRS Incident Reporting and Management Policy](#), all incidents of pica requiring more than basic first aid are reportable incidents.

When a person with a history of severe/extensive pica behavior goes

to medical appointments, the ER and/or is admitted to the hospital, be sure staff in the medical office, ER, and/or hospital are aware of (and document) the pica behavior (and the types of items that have been ingested in the past) along with the preventive strategies. If there are abdominal symptoms, then the work up may include ruling out an ingestion of an inedible. It is also necessary to make the immediate environment free of items the person is known to ingest (e.g., gloves, tacks, etc.).



Continuity of Care

Across Settings

People receive services and supports in a variety of settings (day program, school, community job, etc.).

Upon review of the Comprehensive Surveys conducted from 7/01/2011 through 09/30/2011, 34 individuals were found to not have continuous and consistent services and supports from each of his/her providers. The primary reasons for these negative findings were:

- Lack of documentation that

services and supports were provided in accordance with the person's support plan and the provider's policies and procedures; and

- Lack of implementation of systems that other providers have developed for the individual (i.e., medication administration system, seizure management system, health-related incident management system, behavioral support plan).

Continuity of care across all set-

tings is critical for ensuring health and safety. Ensuring residential staff, day program staff, job coaches, teachers, school personnel, etc. are trained on any risk plans prior to *Day 1* of providing supports/services is vital. Risk plans cover a wide range of issues. Some of the more common risk plans that are critical for anyone working with/providing services for a person with IDD to be aware of and trained on prior to day 1 of providing supports/services include dining plans, choking prevention plans, pica prevention plans, seizure management plans, fall prevention plans

Continuity of Care (cont.)

and bowel management plans. Equally important, is that as a risk plan is updated, everyone in all settings is timely trained on the updated plan.

The MRC identified a number of examples where the above did not take place. Four such examples along with recommendations for prevention follow.

One example, a person has a choking prevention plan in place. He is going to begin attending day program with plans to eat lunch while at day program. Day program staff should receive a copy of the choking prevention plan, have the necessary adaptive equipment in place (if applicable), know the correct texture and consistency of food and liquid to be offered, and receive training on the plan prior to the first time he eats lunch at day program.

Another example relates to seizure management. People (residential staff, day program staff, school personnel, job coach, etc.) that work with a person with seizures should have a copy of the individual-specific seizure protocol and be familiar with the contents of the

protocol such as What type of seizures occur? Is Diastat supposed to be administered? If so, when? When should 911 be called? What safety measures are in place to ensure safety during bathing?

A third example relates to a fall prevention plan. It is important that staff are aware the person is a fall risk and the individual-specific prevention techniques that should be implemented.

And yet another example relates to pica behavior. Staff in all settings should be aware of the person's diagnosis of pica, the items frequently targeted, and the strategies to implement to ensure the environment (in all settings) is as risk free as possible.

Across Staff (Staff Training)

Staff training on the topics listed in IAC 6-14-4 is to be completed prior to a staff person working with a person receiving services/supports.

There are a variety of training methods that are currently utilized by provider agencies. One of the least effective techniques is the

"read on your own and sign" technique. Effective and successful training requires preparation and a time commitment from both the trainer and the trainee. In addition to covering the topic from start to finish, it is suggested that enough time is allotted to answer questions, address concerns, and/or clarify any points of confusion.

Provider agencies are required to have a system for documenting the training of each employee. This system includes the type of training provided, the name and qualifications of the trainer, the duration of training, the date(s) of training, the signature of the trainer verifying the satisfactory completion of training by the employee, and the signature of the employee (IAC 6-16-3).

Upon review of the provider compliance reviews conducted (CERT Reviews) from 11/01/2010 through 09/30/2011, a number of providers were found to not have sufficient documentation of training. As can be seen from Figure 1, the majority of providers were found out of compliance due to a lack of documentation in the area of provider qualifications.

Providers must have a written training procedure that includes the following:

...
"(2) A system for documenting the training for each employee or agent, including:

(A) the type of training provided;

(B) the name and qualifications of the trainer;

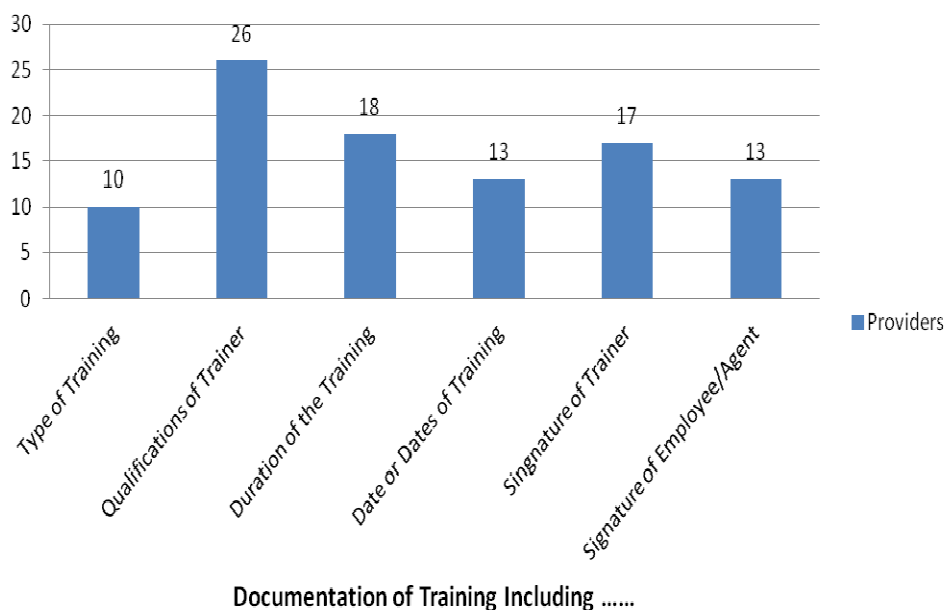
(C) the duration of training;

(D) the date or dates of training;

(E) the signature of the trainer, verifying the satisfactory completion of training by the employee or agent; and

(F) the signature of the employee or agent."

Figure 1: CERT Negative Findings Associated with Training Documentation (11/1/10-9/30/11)



460 IAC 6-16-3
Policies and
procedures
documentation



***During the 143
CERT reviews
conducted from
11/01/2010 to
09/30/2011, 25
direct care files
reviewed were found
to not contain
documentation on
managing
individual specific
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interventions.***

Continuity of Care (cont.)

Verification of satisfactory completion of training can be completed in a variety of ways depending on the topic and skill level required. Verification can be obtained via successful completion of a written post-training test or observation of the staff satisfactorily completing the task (e.g., medication administration, safe transfer, etc.). Another option to verify staff knowledge is to provide a scenario. When the staff provides the preferred response, the staff has demonstrated the ability to understand the facts and apply them to real-life scenarios.

Receiving reference materials during training or knowing where to find pertinent documents provides staff the opportunity to review the material after the training session.

Staff training on individual-specific risk plans and mitigation strategies is vital. During the 143 CERT reviews conducted from 11/01/2010 to 09/30/2011, 25 direct care files reviewed were found to not contain documentation on managing individual specific treatments and interventions. Staff

should have a foundation of knowledge regarding the risk and an understanding of how the risk is reduced/eliminated for the specific person. Training materials for specific individuals should include an understanding of any individual-specific risk plans, any health care/nursing care plans, significant diagnoses, basic facts and knowledge about a disease process in that individual, any other specific needs of the individual, and side effects of medications prescribed for that individual. Verification of the staff's knowledge and ability can be obtained via completion of a written post-training test or observation of the staff performing the technique.

For skills and techniques such as participating in a two-person lift, assisting with ambulation using a gait belt, preparing a liquid to honey consistency, guiding a person who eats too fast to slow down, de-escalating someone who is upset, etc., the staff should demonstrate to the trainer the correct identification of the situation in which the skill needs to be applied along with the correct steps to complete the task. Staff should not

be allowed to care for a person alone without demonstration of competence/ability to complete the skill successfully.

Provider agencies should ensure that both general training and individual-specific training is updated periodically and that there is a system in place to ensure all staff complete these updates (IAC 6-14-4, IAC 6-16-3).

Whenever there is a new diagnosis, treatment, medication, need for a new technique to be utilized, etc., training should be completed prior to caring for the person or at the time the change in condition occurs. Ensuring all staff are trained in a timely manner, may require coordinating schedules of the people involved (e.g., nurse, behaviorist, dietitian, direct support staff, supervisor/team leader, day program staff, etc.).



Choking that requires intervention is a reportable incident through Indiana's DDRS.

Specialized Diets

During this quarter, MRC reviewed a case where the cause of death was associated with choking as a result of receiving an item that was not in accord with their diet.

During the period from 01/01/2011 through 09/30/2011, there were 149 incidents of choking (requiring intervention) reported to Indiana's DDRS.

When an individual is prescribed a specific diet, either a specific texture (e.g., mechanical soft, ground, pureed, etc.) or specific therapeutic content (e.g., low sodium, low potas-

sium, high fiber, etc.), the provider agency should ensure there is expertise from a dietitian to review the orders and develop recommendations for options/substitutions that are compatible with these dietary orders.

A speech language pathologist would be an appropriate consultant for determining the options/choices for a specific textured diet. A nurse, case manager, etc., is not trained in such expertise and the provider agency should defer to health professionals qualified in this area.

Without sufficient assessment, devel-

opment of a proper specialized diet, and implementation of any associated risk plans, the result is an increased risk of choking.

A Choking Checklist is available at http://www.in.gov/fssa/files/Choking_Checklist.pdf for teams to use when developing and/or reviewing/revising a risk plan for those with identified choking risks.

Medication Administration System and Quality Assurance/Quality Improvement

During MRC's review of deaths that occurred during the most recent period, the following conditions, which increase risk of medication errors, were noted: (a) Medication administration record (MAR) indicates medications are given both orally and via g-tube even when the person is not to receive anything orally; (b) Discontinued medications are not removed from the current MAR; and (c) Multiple entries of the medication (same dosage and close proximity of time, etc.).

Also, during this quarterly period (07/01/2011 through 09/30/2011), there were a total of 2104 medication errors reported to DDRS.

Over the past seven months, this number has been fairly consistent with a monthly range from 618 errors in March 2011 to 758 errors in August 2011 (Table 1 to the right).

The provider agency should ensure periodic observations of medication administration for all staff who administer medication. Providers may find it helpful to use a medication administration checklist to assure medication passes are completed in a thorough and consistent manner.

Providers should routinely review the Medication Administration Records (MAR) and assure any errors are promptly communicated to the pharmacy for correction. This review should include the medication, dosage strength, frequency, vehicle (tablet, suppository, liquid and concentration of liquid), and route.

In the event a person transitions to NPO status (i.e., nothing by mouth), the MAR should be updated to remove such orders and phrases such as 'po' or 'by mouth' and corrected to 'via g tube' or 'via j tube', etc. Without timely correction, staff may inadvertently read

the MAR and follow the printed outdated order (by mouth) if not aware of the NPO status of the individual, placing the individual at risk. Administratively, it is also creating medication errors if the old order for 'by mouth' is not removed from the MAR and replaced with 'via tube,' and staff are administering medication through a feeding tube.

Provider agencies are encouraged to review (and revise as needed) their medication administration policy/procedure to ensure it contains the required components, staff are trained to competency, and a monitoring system is in place. This system should include both a process for reducing individual incidents of medication errors as well as organizational efforts to reduce overall risk of incidents in this category across all consumers.

Table 1: Medication errors reported to Indiana's DDRS from 03/01/2011 through 09/30/2011.

	Medication Errors
Mar-11	618
Apr-11	711
May-11	715
Jun-11	662
Jul-11	688
Aug-11	758
Sep-11	658
Average	687

Areas of Application by Decade of Life

The data presented by **Areas of Application** are aggregated across time. Data presented include the most recent period and documents the persistent nature of the conditions noted.

- For the four causes of death tracked (cardiovascular, respiratory, cancer, and sepsis), respiratory deaths (26%) were the most common cause of death in those who die under the age of 30 (Table 2);
- Sepsis appears to cause about 9-10% of all deaths in each decade of life (Table 2) reinforcing the importance of team members recognizing early health status changes that occur with sepsis. Some examples include either fever or development of a low body temperature, generalized weakness, dizziness, rapid pulse, rapid breathing, low blood pressure, rapid onset of confusion, agitation.

Table 2: Most Common Causes of Death per Decade of Life (Deaths reviewed by MRC 10/01/2008 through 09/30/2011).

Decade	Total Number of Deaths	Cause of Death			
		Cardio-Vascular	Respiratory	Cancer	Sepsis
<30	102	14%	26%	3%	10%
30s	87	15%	11%	9%	9%
40s	121	16%	17%	9%	7%
50s	256	18%	10%	15%	11%
60s	278	17%	18%	10%	9%
70s	179	26%	8%	9%	9%
80s	115	16%	13%	16%	7%
90+	22	9%	9%	9%	0%
Total	1160	18%	14%	11%	9%

*Percentages calculated horizontally

Areas of Application by Decade of Life (cont.)

- For each decade in which death occurs, there are associated comorbid conditions. These represent a profile of common chronic illness at the time of death. Although they may not be the cause of death, staff should be familiar with signs and symptoms of these illnesses and worsening illness and how and to whom to report these signs and symptoms as well as how to assist in treating these comorbid conditions. For instance, in those who died under the age of 30, the most common comorbid conditions tracked included G-tube placement, dysphagia, GERD, and seizures;
- For those who died in the fifth decade of life, the comorbid conditions varied and included Down's syndrome, dysphagia, GERD, hypothyroidism, and seizures;
- Sleep apnea was more commonly found in those who died at earlier ages (through the fourth decade);
- The most common comorbid conditions identified throughout all decades included GERD and seizures (which had a prevalence of over 40%), dysphagia (which had a prevalence of 38%), dementia (which both had a prevalence of 28%), and hypothyroidism (which had a prevalence of 25%). Twenty-three percent (23%) of those who died throughout the decades had a G-tube present at the time of death. Fourteen percent (14%) of the people who died had Down's syndrome (Table 3).

Table 3: Various Health Categories per Decade of Life (Deaths reviewed by MRC 10/01/2008 through 09/30/2011).

Decade	Total Number of Deaths	Comorbid Health Conditions								
		Dementia	G Tube	Down's	Dysphagia	CVA	GERD	Hypothyroidism	Sleep Apnea	Seizures
<30	102	1%	43%	5%	25%	5%	30%	13%	13%	57%
30s	87	1%	31%	9%	32%	5%	38%	21%	13%	54%
40s	121	12%	31%	17%	36%	7%	40%	31%	14%	45%
50s	256	27%	20%	30%	42%	5%	43%	31%	8%	48%
60s	278	35%	21%	19%	40%	11%	43%	27%	6%	41%
70s	179	35%	16%	3%	36%	15%	46%	23%	4%	29%
80s	115	52%	16%	0%	43%	14%	45%	17%	2%	23%
90+	22	68%	5%	0%	32%	14%	32%	14%	0%	9%
Total	1160	28%	23%	14%	38%	9%	42%	25%	8%	41%

*Percentages calculated horizontally.

Areas of Application by Level of IDD

Table 4: Cause of Death per Level of IDD (Deaths reviewed by MRC 10/01/2008 through 09/30/2011).

Level of IDD	Total Number of Deaths	Cause of Death			
		Cardio-Vascular	Respiratory	Cancer	Sepsis
Borderline	8%	11%	7%	13%	6%
Mild	29%	33%	23%	44%	23%
Moderate	18%	19%	16%	21%	23%
Severe	15%	13%	16%	8%	18%
Profound	27%	21%	32%	11%	28%
Unknown	3%	3%	5%	3%	2%
Total	1160	206	166	126	104

*Percentages calculated vertically.

- For those with borderline, mild, moderate, or severe IDD, death peaked in the sixth decade;
- In the profound IDD population, death had a double peak – 15% died under the age of 30, and 25% died in the fifth decade. The double peak may reflect those born with severe congenital, metabolic and functional disabilities who were unable to survive to age 30;
- Thirty-three percent (33%) of all cardiovascular deaths occurred in the mild IDD population;
- For respiratory causes of death, 23% occurred in the mild IDD population and 32% occurred in the profound IDD population;
- Respiratory conditions were the most common cause of death in the profound IDD population;
- Deaths due to sepsis occurred throughout all levels of IDD;
- Forty-four percent (44%) of all cancer deaths occurred in the mild IDD population (Table 4).

Areas of Application by Level of IDD (cont.)

- GERD was associated with a high percentage for each level of IDD at the time of death (39-44%);
- The prevalence of dementia at the time of death peaked in those with severe IDD (39%);
- The prevalence of G-tube placement at the time of death peaked in those with profound IDD (39%);
- The prevalence of Down's syndrome at the time of death peaked in those with severe IDD (28%);
- The prevalence of dysphagia at the time of death peaked in those with profound IDD (51%);
- The prevalence of hypothyroidism at the time of death peaked in those with severe IDD (28%).

Table 5: Various Health Categories per Level of IDD (Deaths reviewed by MRC 10/01/2008 through 09/30/2011).

Level of IDD	Total Number of Deaths	Comorbid Health Conditions								
		Demen- tia	G Tube	Down's	Dys- phagia	CVA	GERD	Hypothy- roidism	Sleep Apnea	Seizures
Borderline	95	25%	21%	1%	33%	7%	39%	25%	13%	23%
Mild	336	26%	12%	7%	27%	11%	39%	23%	9%	36%
Moderate	208	29%	13%	21%	32%	12%	44%	25%	8%	34%
Severe	173	39%	26%	28%	45%	10%	41%	28%	8%	46%
Profound	317	22%	39%	13%	51%	7%	44%	26%	5%	56%
Unknown	31	39%	26%	19%	32%	3%	35%	19%	3%	26%
Total	1160	28%	23%	14%	38%	9%	42%	25%	8%	41%

*Percentages calculated horizontally.

Areas of Application by Setting

- In the DD waiver setting, 22% of all deaths were due to cardiovascular causes and 13% were due to sepsis;
- In the SGL, LP-ICF, and SS settings, cardiovascular deaths were also the most common cause of death of those categories tracked;
- In some instances, a person is moved to a nursing home setting when his/her medical needs are paramount and he/she requires 24-hour skilled nursing care, usually at the end of life. Respiratory causes of death and cancer causes of death may be two important reasons for moving a person to a nursing facility (Table 6).

Table 6: Cause of Death by Setting (Deaths reviewed by MRC 10/01/2008 through 9/30/2011).

Agency Set- ting	Total Number of Deaths	Cause of Death			
		Cardio- Vascular	Respira- tory	Cancer	Sepsis
DD	304	22%	11%	10%	13%
SGL	131	20%	14%	13%	12%
LP-ICF	30	40%	20%	3%	3%
SS	54	24%	11%	11%	4%
Title XX	21	33%	19%	14%	10%
Nursing Home	613	13%	16%	11%	7%
SLI	4	0%	50%	50%	0%
Total	1159	18%	14%	11%	9%

*Percentages calculated horizontally.

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Mortality Reviews

Additional Recommendations from MRC

In addition to the recommendations embedded in the focal areas above, review of deaths by MRC from the period 07/01/2011 through 09/30/2011 produced some additional recommendations that providers should consider. These included:

- Providers should closely monitor clients who receive psychotropic medication, particularly those with polypharmacy. This would include review of symptoms (to capture benefits) as well as observation of potential side effects (associated with the costs of use). *Fact Sheets* on specific psychiatric medications are available to Providers at, <http://www.in.gov/fssa/ddrs/3948.htm>;
- When a person is admitted to a psychiatric unit, Providers should consider initiating Medicaid PA hours;
- Providers should assure that they have the appropriate staffing levels required to provide the amount of care and level of service identified within an individual's plan. This is particularly important for those who require additional supervision as a result of behavioral or medical complications (e.g., falls);
- Provider staff need to be alert to changes in a person's health status. Providers should examine their training on Health and Wellness (required training topic per 460 and DDRS Policy: Requirements & Training of Direct Support Professional Staff) and assure a portion is dedicated to the recognition and response to changes in health status. The *Fact Sheet: Signs and Symptoms Indicating a Change in Status* is available as a resource to Providers (http://www.in.gov/fssa/files/signs_and_symptoms.pdf);
- When a person transitions to another Provider, it is imperative that sufficient attention is provided to the communication and training of new staff on risk plans. For more information pertaining to this area, please refer to the section on **Continuity of Care** beginning on page 2 of this communication;
- During any medical or dental procedure, Providers should have sufficient communication with the treating team to facilitate development of an appropriate discharge plan. This may include an increase in supervision and/or medical monitoring to reduce risk of a post procedure complication. Providers should consult the following *Fact Sheets* for additional information:
 - Dental Appointment: After the Appointment (http://www.in.gov/fssa/files/dental_appointments_4.pdf);
 - Emergency Room: After Discharge from the Emergency Room (http://www.in.gov/fssa/files/emergency_room_3.pdf);
 - Hospitalization: After Discharge (http://www.in.gov/fssa/files/hospitalization_3.pdf).

About Mortality Reviews...

Mortality review is part of the overall Risk Management scheme operated for DDRS/Bureau of Quality Improvement Services (BQIS) by Liberty of Indiana Corporation. The department operates as a part of the BQIS organization and is designed to specifically look at the deaths of individuals served by DDRS.

